

REGISTRATION DISTRICT OF MISSOURI
 DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

LED VS SEP 8 1960 318

1003

-60-032918

STATE FILE NUMBER

8488

DED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE				b. COUNTY							
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis				Length of stay in 1b 7 years				c. CITY OR TOWN St. Louis				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4226 Penrose				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				d. STREET ADDRESS (If outside, give location) 4226 Penrose				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle E. Last STEINMANN				4. DATE OF DEATH Month Aug. Day 25 Year 1960											
5. SEX male		6. COLOR OR RACE white		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 9/3/1883		9. AGE (last birthday) 77		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) printer				10b. KIND OF BUSINESS OR INDUSTRY newspaper				11. BIRTHPLACE (City and state or country) St. Louis Mo.				12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME August Steilmann				13b. MOTHER'S MAIDEN NAME Louise Doeding				14. NAME OF HUSBAND OR WIFE none							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 498-22-0782				17. INFORMANT Ernest Steinmann - #7 Hob Hill Dr.				Address St. Louis Co., Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage												INTERVAL BETWEEN ONSET AND DEATH 3 Days			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis												3 Years			
DUE TO (c) 331 X												PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N- <input type="checkbox"/> Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)															
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)											
20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input checked="" type="checkbox"/> p.m. Month, Day, Year															
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				20f. CITY, TOWN, OR LOCATION				COUNTY STATE			
21. I attended the deceased from Aug 10 to Aug 25 and last saw him live on Aug 25-60 Death occurred at 8:00 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE Francis J. Medler MD (Deputy or title)						22b. ADDRESS 7114 W Florissant						22c. DATE SIGNED 8/26/60			
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 8/29/1960		23c. NAME OF CEMETERY OR CREMATORY New Bethlehem Cemetery				23d. LOCATION (City, town, or county) (State) St. Louis County Mo.							
24. FUNERAL DIRECTOR Buchholz Mortuary 5967 W. Florissant				25. DATE RECD. BY LOCAL REG. AUG 29 1960				26. REGISTRAR'S SIGNATURE Robert Smith. M.D.							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Wilfred A. Beech

Licensed Embalmer No. 4558

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.